



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

ORTHOTEXAS PHYSICIANS AND SURGEONS  
4780 N JOSEY LANE  
CARROLLTON, TX 75010

#### **Respondent Name**

ACE AMERICAN INSURANCE CO

#### **Carrier's Austin Representative Box**

15

#### **MFDR Tracking Number**

M4-12-1596-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary from Table of Disputed Services:** "carrier denied for timely filing- we file electronically and submitted proof of timely filing but they still denied"

**Amount in Dispute:** \$110.92

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "ESIS maintains its denial of services billed fro 04/15/2011 as the bill was not filed timely. Further review by our 3<sup>rd</sup> party repricer has determined that there does not appear to be any relationship to any PPO discount.

**Response Submitted by:** ESIS, PO Box 6563, Scranton, PA 18505

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
04/15/2011	99213, 99080-73	\$110.92	\$110.92

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. 28 Texas Administrative Code §129.5 sets out the procedures and reimbursement for Work Status Reports.

5. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of Workers' Compensation Professional Services provided on or after March 1, 2008.
6. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
7. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - Explanation of benefits dated 08/15/2011
    - 1- (29)- The time limit for filing has expired.
  - Explanation of benefits dated 11/14/2011
    - 1-(29)- The time limit for filing has expired.
  - Explanation of benefits dated 11/28/2011
    - 1-(29)- The time limit for filing has expired.
    -

### **Issues**

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. Pursuant to 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor code §408.0272...a health care provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the services are provided." No documentation was found to support that Texas Labor Code §408.0272 applies to the service in dispute. For that reason, the requestor in this dispute was required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus 5 days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. Review of the documentation submitted by the requestor finds a Claim History Report from Realmed. This report shows that an electronic claim was submitted and confirmed received by respondent on 04/21/2011.
3. In accordance with Texas Labor Code §408.027, the Requestor has timely submitted bill to the respondent with 95 days after the date the services were provided. Therefore, reimbursement is recommended per 28 Texas Administrative Code §134.203 as follows:

CPT code 99213: 54.54 WC CF/33.9764 Medicare CF x 66.90 Participating amount= \$107.39

The requestor is seeking \$95.92. This amount is ordered.

CPT code 99080-73: \$15.00 is recommended per 28 Texas Administrative Code §129.5(i)

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$110.92.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$110.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

04/30/2012  
\_\_\_\_\_  
Date

***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**